Optimal Whole Health & Nutrition

Thank you for joining us today on your journey to getting well! You do want to get well, right?

Name: _____ Today Date: _____

Address: _____ Date of Birth: _____

_____ Email: _____

Cell: _____ Home #: _____

Referred by: _____

What Current Diagnosis's do you have: (by you or your doctor) _____

_____

_____

Current Medicine/Supplements/Oil are you taking:_____

_____

_____

External Complaints: (Body, Skin, Hot/Cold, environment _____

_____

_____

_____

Internal Complaints:(pains, habitual habits, negative behaviors, discomfort, aches_____

_____

_____

_____

Chronic or Come & Go Conditions: _____

_____

How long have these issue been a problem: (years/months) _____

What's your reason for coming in today? _____

_____

What is the outcome you hope to get from your visit today: _____

_____

* By signing below, you understand we are not doctors or nurses, we are NRT Practitioners & Kinesiologist's doing Muscle & Supplement Testing. You agree that all the information is correct and as accurate as possible.

_____ _____

Your Signature Date

Nutrition Response Test

By using OWHN services you are made fully aware NRT use this system as an "adjunct" to further ANALYZE a client's body to assist in determining possible UNDERLYING CAUSES which may be contributing to non-optimal health conditions.

When the UNDERLYING CAUSE of the problem is found, it is not "TREATED." We will assist the client in helping his/her body CORRECT THE CAUSE by supplying appropriate NUTRITIONAL SUPPORT and LIFESTYLE GUIDANCE to the patient to facilitate more normal (physiological) function.

We do not PRESCRIBE. We do RECOMMEND and make available certain supplements, and we educate the patient on how and when is the best way to take them, to help bring about a more healthful condition for their body.

Liability of Release I (name) _____, fully aware, have been full informed, understand and acknowledge that Optimal Whole Health & Nutrition is not providing medical services, instead are providing holistic consulting and strategic planning for optimal life.

By signing below I accept and take full responsibility of my health and hereby completely indemnify, hold harmless and release and forever discharge Optimal Whole Health & Nutrition, and its attorneys, agents, servants, representatives, predecessors and successors in interest, from any and all past or present claims, demands, obligations, actions, causes of action, rights, damages, costs, expenses, attorney's fees and compensation of any nature whatsoever, whether based on contract, tort, or any other theory of recovery, and whether for compensatory or punitive damages, which it have ever had, or which has accrued or otherwise may be acquired, including but not limited to all such claims on account of, or in any way arising from or relating to, or arise out of the services or future services proved by Gina Yarrish or Optimal Whole Health & Nutrition, its successors, assigns, affiliates, employees, agents, attorneys and servants.

Signature _____. Date _____

Touch for Heal Kinesiology, use of supplements and consulting/coaching

I agree to take full responsible for my life, my health, and my actions. I understand that what is going on in my life and health is directly related to my beliefs, thoughts, and actions. By signing below, I will do whatever it takes to align my beliefs and actions to reach my highest optimal life and health. I agree not to let myself down and do what is necessary to accomplish my goal.

Signature _____. Date _____

CONSENT, LICENSE AND RELEASE AGREEMENT

I, the undersigned, hereby grant my permission and consent to Optimal Whole Health & Nutrition ("Optimal") and its affiliates, officers, agents, and employees (together, "Optimal Representatives") to photograph, Video record, or audio record me.

I hereby grant an irrevocable, world-wide, royalty-free right and license to Optimal and Optimal Representatives to utilize, adapt, modify, reproduce, distribute, publicly perform and display the photographs, video, and/or audio (collectively "Media") taken of me for use in promotional, educational, informational, advertising or commercial materials and communications in any form now known or later developed, including but not limited to publications, websites, articles, brochures, books, magazines, newsletters, exhibits, videos, films, social media, advertisements, and training programs (collectively "Materials"). Furthermore, I hereby authorize and consent to the use of my name, image, likeness, and voice (collectively, "Likeness") in the Media for all Materials or any other purposes deemed appropriate by Optimal.

I hereby waive any right to be notified or to inspect or approve the Media or any Materials that are created using my Likeness, now or in the future, whether that use is known or unknown to me. I hereby waive any right to royalties or other compensation arising from or related to the use of the Media or Materials. I hereby release and hereby agree to indemnify and hold harmless Optimal and its Members, Optimal Representatives, and its licensees and assigns for any and all claims that I or any third party may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation, or any other cause of action arising of the use, utilization, adaptation, modification, reproduction, distribution, publicly performance or display of my Likeness in the Media or Materials. In accordance with this complete release of all rights in my Likeness used in the Media and Materials, I hereby waive any and all claims, damages, or liability arising from or related to the use of the Media, including but not limited to any misuse, distortion, blurring, alteration, optical illusion, or use in composite form, either intentionally or otherwise, of my Likeness that may occur or be produced in taking, processing, reducing; adapting, modifying, producing, reproducing of the Media and Materials and their publication, distribution, display or performance.

I understand and agree that Optimal is and shall be the exclusive owner of all right title and interest, including any copyright, in the Media and Materials.

I have read this Consent, License and Release before signing below, and I fully understand the contents, meaning, and impact of this Consent, License and Release. This Consent, License and Release shall be binding upon and inure to the benefit of my successors and assigns and contains the entire understanding of the parties with regards to the Media and Materials.

I hereby represent that I am eighteen (18) years of age or older and I am competent to contract in my own name.
Name (print) Email Phone Number

Signature _____ Date _____

I hereby certify that I am the parent and/or legal guardian of the above-named minor and do hereby give my consent without reservation to Optimal on behalf of such minor child.

Name (print) _____

Signature of Parent or Legal Guardian _____ Date _____

Do you understand everything you have read above? Please write in YES/NO _____

Optimal Whole Health & Nutrition

New Patient Introduction Form

Patient Name: **Date:**

1. **Chief Concerns:**

2. **Medications and/or Nutritional Supplements currently on:**

3. **Dietary Intake for 2 days before appointment:**

Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**

Professional Wellness Alliance

Membership Agreement

Who We Are: The Professional Wellness Alliance is on a mission to assure that holistic providers have a defendable basis for offering their services and to bring individuals and families together with PWA licensed providers to learn ways to have the best in health.

How it Works: Licensed providers, Individuals and families join in a private member community to share the services defined below. The PWA is structured as a private community that requires licensing for providers to assure provider ethics, competency, and quality services along with good community order.

Services Provided: PWA licensed providers are authorized to assist members through health education, instruction and products.

Services Not Provided: PWA licensed providers do not offer any state licensed health services, DO NOT take responsibility for the health of any person or for the diagnosis, treatment or resolution of any symptom or condition.

How Do I Enroll as A Member: You may enroll as a PWA community member through the PWA website at https://www.pwai.us/become-a-member or through a PWA provider and you must agree to be accountable to the member rules shown below.

Agree that Provider Members (PWA Licensees) provide only the services described above under "Services Provided" and that these are self-help and educational services not medical services.

1. Agree that all records of services you receive are available to you upon request as "private member educational records" and not medical records;
2. Agree that the Professional Wellness Alliance does it's best to assure the integrity and competence of Provider Members (Licensees) and while Licensees represent the PWA mission, that they are independent educators that do not work for the PWA. Therefore, you agree to hold the PWA and affiliates harmless in all matters related to your association with PWA, affiliates or Provider Members;
3. Agree to make your best efforts to resolve any and all complaint you may have with another member with them personally and in the event you are unable to resolve satisfactorily, agree to settle any dispute or complaint through binding arbitration through a mutually agreed arbitrator;
4. Agree that any and all content on the PWA website, newsletters, writings, affiliate links or otherwise are for educational purposes only and are not intended as medical advice.

Term and Cancellation: Membership in the PWA shall begin when you agree to this Membership Agreement and shall terminate with written notice from you to the PWA or from the PMA to you. The PWA reserves the right to deny or terminate membership of any member without cause. Termination shall not waive or relieve you of any obligations or agreements made while you were an enrolled member.

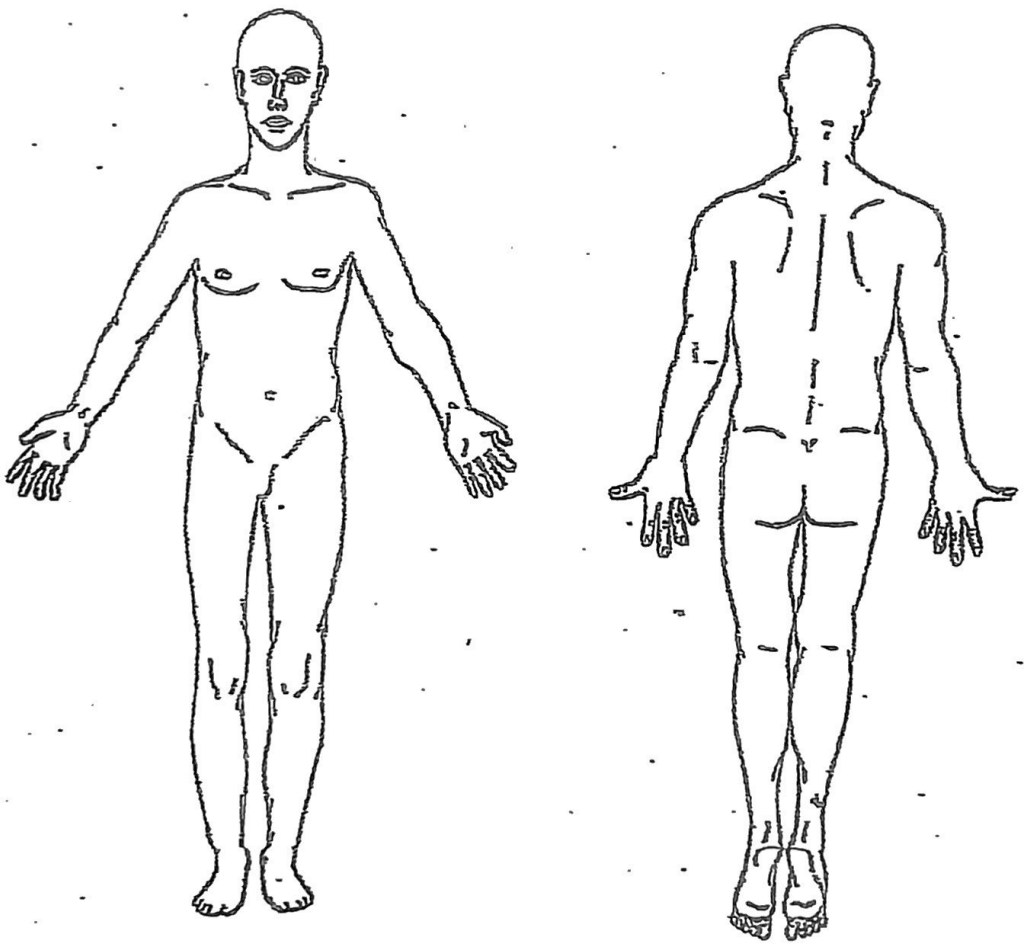
By placing your signature below or agreeing to membership though the PWA on-line electronic system you accept membership and agree that this agreement is a "contract" binding you to follow the herein terms.

_____	_____	_____
Member Name	Date	Address
_____	_____	_____
City / State / Zip	Email / Phone	Member Signature

Enrolled Into Membership By: _____ PWA Provider #_____

Natural Health Improvement Center
NEW PATIENT INFORMATION FORM

Please Mark All Scars Below, Including Surgeries, Injuries, Piercings, Tattoos, and Childbirth (Episiotomy, Caesarian) Scars



Notes:

Systems Survey Form | Restricted to Professional Use

Standard Process

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you **If a symptom does not apply, don't circle anything** for that symptom

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ ___ ___ TOTAL
1 2 3

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ ___ ___ TOTAL
1 2 3

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ ___ ___ TOTAL
1 2 3

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ ___ ___ TOTAL
1 2 3

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ ___ ___ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ ___ ___ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ ___ ___ TOTAL
1 2 3

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminished
133. 1 2 3 Reduced initiative

___ ___ ___ TOTAL
1 2 3

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

___ ___ ___ TOTAL
1 2 3

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

___ ___ ___ TOTAL
1 2 3

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

___ ___ ___ TOTAL
1 2 3

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

___ ___ ___ TOTAL
1 2 3

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that something bad is going to happen)
187. 1 2 3 Nervousness causing loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

___ ___ ___ TOTAL
1 2 3

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate too frequently
198. 1 2 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

___ ___ ___ TOTAL
1 2 3

MALE ONLY

202. 1 2 3 Less involved in exercise/social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seem softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminished sex drive

___ ___ ___ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion
_____ Hydrochloric Acid Point
_____ Enzyme Point
_____ Murphy's Sign

Large Intestine (Palpate)
_____ Ascending
_____ Transverse
_____ Descending

Adrenals
Pass/Fail Pupil Dilation Exam
Postural Hypotension
_____ Supine
_____ Standing

Pass/Fail Zinc Taste Test
Pass/Fail Cuff Test
_____ Cuff Pressure
_____ pH of Saliva
_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.